Division of Medical Assistance
Guidelines for PCS Provider QA/UR Follow-Up

The Personal Care Services Quality Assurance/Utilization Review program includes provider and recipient visits by DMA's contractor The Carolinas Center for Medical Excellence (CCME). During provider visits, CCME staff conducts an audit of the PCS provider's records in order to determine whether the provider's documentation is in accordance with the requirements set forth in clinical policy. Recipient service validation visits are then conducted in order to determine if the provider's PCS recipients appear to be appropriate for PCS as documented in the provider's records. The provider visits are intended to identify areas to improve overall performance and compliance with DMA Policy in the PCS program while providing educational opportunities for providers.

Key aspects of PCS delivery have been established and are captured on a provider review tool used by CCME during the review visits. Each aspect of care has pre-established benchmarks (goals) for provider performance and unacceptable thresholds which may indicate additional reviews by Program Integrity and/or corrective action plans. At the provider review, if a provider is measured above the unacceptable threshold but less than the goal, the provider should be alert to performance issues which should be addressed internally by the provider as they have an identified opportunity to improve their services. These key aspects of care are weighted to differentiate critical deficiencies from non-critical deficiencies in policy and practice. Provider self-audit/QA Plans addressing deficiencies discovered internally prior to the CCME review are incorporated into the CCME compliance score.

In addition, CCME registered nurses provide recipient validation visits in conjunction with the provider administrative record review. The recipient validation visit is looking at PCS eligibility, services provided and satisfaction. The results of validation visits are included in the provider's overall deficiency type calculation. For example, if a provider scored well in their recordkeeping & documentation, but the results of recipient service validation visits revealed that a significant amount of their recipients did not appear medically appropriate for PCS, the overall deficiency type calculation would be affected.

After CCME conducts the provider review and recipient validation visits they submit findings to DMA. The type of follow-up action required by the provider is determined by the type and amount of deficiencies. Type 1 and Type 2 findings will result in the provider having to submit a Correction Action Plan (CA Plan). DMA will determine if the plan is acceptable and provides strategies to remedy the identified deficiencies. DMA will take into consideration a provider's CA Plan that addressed all of the identified noncompliance findings if this Plan was in effect prior to the CCME compliance audit. As a component of this CA Plan, providers will be required to conduct a reassessment whenever the CCME recipient validation visits result in findings that the services do not appear appropriate.

The deficiencies are weighted considering critical key aspects, key aspects below unacceptable thresholds and provider self-audit/QA Plans prior to review. DMA will notify the provider with a letter of findings, which indicates the type of deficiency, the summary of findings and actions required for follow up.

Key Aspects of PCS Care **Shaded aspects are considered critical key aspects of care.**		
ID #	Key Aspect	Benchmark/ Unacceptable threshold
1a	Provider (self-audit) record reviews are current.	100%/≤80%
1b	Provider (self-audit) record reviews are complete.	100%/≤80%
1c	Provider complaint management system is current and implemented.*	100%/≤80%
2a	PCS PACT documents medical condition related to need for PCS.	100%/≤70%
2b	Deficits in activities of daily living (ADLs) are based on medical condition (mobility, eating, bathing, dressing, toileting, continence)	100%/≤70%
2c	Recipient assessment supports ADL deficits and identified needs.	100%/≤70%
2d	Recipient rights reviewed and documented.*	100%/≤70%
2e	PCS PACT signed by physician within 60 days of the verbal or recorded order.	100%/≤70%
2f	PCS PACT/assessment completed by PCS certified RN.	100%/≤70%
2g	Hours are consistent with identified needs (time and task guidance or exception documented).	100%/≤70%
3a	Days/times based on tasks/needs.	100%/≤70%
3b	Plan of care (POC) based on ADL deficits/identified needs/tasks and are included in the POC.	100%/≤70%
3c	Instrumental ADL (IADL) based on medical condition/ADLs/identified needs.	90%/≤70%
4a	Tasks in POC documented on daily service notes.	100%/≤70%
4b	Deviations to the POC or schedule are documented.	100%/≤70%
4c	Weekly ADL tasks exceed weekly IADL tasks as documented on the daily service notes.	100%/≤70%
4d	Times/days match POC/authorization.	100%/≤70%
5a	Recipient satisfaction/perception of services documented.	90%/≤70%
5b	Supervision is timely (every 90 days and unplanned lapses).	100%/≤70%
5c	Supervision meets standards: condition, continued service need, updates plans as needs change.	100%/≤70%
5d	Follow-up to complaints is conducted in accordance with Division of Facility Services (DFS) requirements and provider policy.*	100%/≤90%
6	Services billed reconcile with authorized and provided services.	100%/≤70%
7	Validation visits of recipient – appropriate and eligible	100%/≤ 79%- *note if this is 50% or less an automatic referral to PI will be done*

*****Non-compliance in aspects (1c, 2d, 5d) results in automatic referral to DFS.

Deficiency Types and Required Follow-Up by Provider				
Deficiency Type	**Description**	**DMA Clinical Policy Action**	**Provider Action**	**DMA Program Integrity Action**
1 ***Subject to more frequent reviews & required periodic reports on progress on CA Plan***	**Non-compliant Type 1** At or below unacceptable threshold in: • 1 or more critical key aspects: 2a, 2b, 2c, 2f, 6 **or** • 2 or more critical key aspects: 2e, 2g, 3a, 3b or 4a • Key aspect 7: below 50% in validation visit findings **Compliant Type 1** Provider is at or below unacceptable thresholds HOWEVER, they have identified deficiencies at the provider self audit and have implemented a CA Plan before the CCME audit **Automatic Referral to Program Integrity** Non-response by due date to: • CCME request for records, **or** • DMA request for corrective action plan (CA Plan), **or** • CCME or DMA request for additional information	Send notification letter of review results and requirements for follow-up to provider by certified mail; include CA Plan guidelines. Within 30 days of receipt, review CA Plan and reassessments of recipients found not to meet medical necessity criteria/eligibility at the CCME validation visit. Notify provider of acceptance (or not) of CA Plan and further requirements. Copy to Program Integrity (PI). Transfer copies of all CCME audit documentation to PI (records, emails, and other correspondence) when requested by PI after review of CA plan. Participate, if needed, in provider appeals at all levels. Develop and maintain a centrally available CA Plan database.	**Non-compliant Type 1** Develop a CA Plan in format specified by DMA to remedy identified deficiencies; submit to DMA no later than 30 days from the date of the signature accepting the DMA certified notification letter. Include reassessment of recipients not meeting medical necessity or not qualifying for services as observed in the CCME validation visit. Make report to DMA of action taken. This may include billing adjustments as indicated by the CA Plan. **Compliant Type 1** Provider submits a copy of preexisting corrective action plan in process for review Reassess recipient's not meeting medical necessity or not qualifying for services as observed in the CCME validation visit and make report to DMA of action taken. This	Receive and review all documentation transferred from Clinical Policy. Review documentation and open cases as indicated. Recoup inappropriate payments and/or implement other provider sanctions. Manage case activities involving provider appeals.

		Focus provider communications on audit findings and CA Plan requirements to continually improve the services and program quality. Review progress reports as submitted each 90 days.	may include billing adjustments as indicated by the CA Plan. Cooperate with DMA Clinical Policy and Program Integrity throughout follow-up process.	

Deficiency Type	Description	DMA Clinical Policy Action	Provider Action	DMA Program Integrity Action
2 ***Subject to more frequent reviews & required periodic reports on progress on CA Plan***	**Non-compliant Type 1** At or below unacceptable thresholds in: • 1 critical key aspects: 2e, 2g, 3a, 3b, 4a **or** • 2 or more of the non-critical key aspects: 1a, 1b, 1c, 2d, 3c, 4b, 4c, 4d, 5a, 5b, 5c, 5d. • Aspect 7: At 51-79% recipients eligible at validation visit **Compliant Type 1** Provider is at or below unacceptable thresholds HOWEVER they have identified deficiencies at the provider self audit and have implemented a CA Plan before the CCME audit	Send notification letter of review results and requirements for follow-up to provider by certified mail; include CA Plan guidelines; In completing or reviewing the CA plan. Within 30 days of receipt, review CA Plan and reassessment data and notify provider of acceptance (or not) of CA Plan and any further requirements. Enter all information into CA Plan database and assure provider compliance with requirements. Review progress reports submitted in 90 days and determine additional reports are needed Request records for additional desk review/audit if indicated.	**Non-compliant Type 1** Develop a CA Plan in format specified by DMA to remedy identified deficiencies. This may include billing adjustments as indicated by the CA Plan. Submit to DMA no later than 30 days from the date of the signature accepting the DMA certified notification letter. Submit all information as requested by DMA. Cooperate with DMA Clinical Policy throughout follow-up process. **Compliant Type 1** Provider submits a copy of preexisting corrective action plan in process for review Reassess recipient's not meeting medical necessity or not qualifying for services as observed in the CCME validation visit and make report to DMA of action taken. This may include billing adjustments as indicated by the	None

			CA Plan. Cooperate with DMA Clinical Policy and Program Integrity throughout follow-up process.	
3	At or below unacceptable thresholds in <u>1</u> non-critical key aspects: 1a, 1b, 1c, 2d, 3c, 4b, 4c, 4d, 5a, 5b, 5c, 5d. <u>Key aspect 7</u>: 80-95% recipients eligible at validation visit	Send notification letter of review results to provider. *Though not automatic requirement for this deficiency type, DMA reserves the right to require a CA Plan.*	None *If DMA requires CA Plan, provider action is the same as above in Tier 2.*	None
4	At goal in all key aspects	A letter and audit findings will be mailed to the provider	None	None

PCS Recipient Deficiencies – Validation Visits

Key aspect 7 measures PCS eligibility based on the CCME provider and recipient validation visits. Key aspect #7 measures eligibility for PCS services as assessed by the CCME RN and is defined as deficits in 2 ADLs requiring hands on assistance.

DMA recognizes most of the recipients are medically stable and chronically ill. For example, the difference between a score of 0 (independent) and 3 (extensive assistance) or 1 (supervision) and 4 (total dependence) with no documentation/rationale to identify the change would be a significant variance. A significant variation would not be common place between provider assessments and CCME assessments

If the provider disputes the results of key aspect #7, DMA will initiate a recipient validation review. This review may conclude with a recipient in-home visit. The review and/or visit may include:

- PACT done at reassessment after validation visit discrepancy by provider nurse (disputed recipient)
- PACT in place at time of the validation visit

In PACT reviews DMA staff will focus on diagnosis, age, ADL scores and identified needs, plan of care, field 47 (provider expects plan to change)

- New treatments, interventions, and changes in recipients condition and needs documented in record
- Supervisory visit notes before and after CCME RN validation visit
- In home aide service logs surrounding the time of the visit and reassessment
- CCME RN assessments/reviews
- Physician questionnaires/interviews (similar to information collected in PI audit),
- Recipient questionnaire (telephone interview) reflecting recipient history and PCS services provided
- Interviews with provider staff involved in care and service management
- In home aide logs/service notes reflecting care provided
- Recipient visit, if indicated in investigation by DMA staff member